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Project Plan

September 23, 2009

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Project Description & Vision

Mission

To collectively plan, finance and deliver to the consortium services that are mandated and based on community needs in the areas of public safety, public health, human services and administration. The project will deliver services at an optimum level maximizing available resources and distributed fairly in a manner that instills public confidence in government.

Vision

- County Social Services will have developed and implemented a plan to determine the appropriate array and level of services based on an in-depth review.
- County Social Services will have developed strategies to ensure the most efficient delivery of county services.
- County Social Services will provide effective public information efforts. (i.e. enhanced ability to explore and describe county services).
- County Social Services will be involved in highly effective processes to conduct organizational planning thereby enabling it to be a proactive organization utilizing effective planning and analysis tools.
- There will be a high level of county/state cooperation.
- County Social Services will be fiscally sound as evidenced by adequate reserves, an equitable tax policy and adequate revenues to support services.
- County Social Services will effectively use information technology.

Values

- County Social Services commits to the principles of choice, empowerment, and community in developing the county's mental health, mental retardation, developmental disabilities, and brain injured service system.
- County Social Services' Plan will build on the strengths of individuals, families and natural supports. Services will be coordinated, efficient, understandable, and consumer-driven.
- County Social Services will seek opportunities, which enhance existing services and promote a unified, accessible, competent, and accountable delivery system, which is flexible and responsive to individual's needs and desires.
- Community-based provider partnerships will encourage flexibility and assure accountability.
- The County Social Services management plan will be fiscally sound. County Social Services will responsibly invest and manage financial and human resources.

- County Social Services staff will be present, safe, welcoming, purposeful, productive and competent.

Project Initiatives

County Social Services is a consortium of counties dedicated to making the mental health & disability system better by trying. We try by acting on the feedback of our stakeholders and community. Here are the three initiatives that summarize much of our action.

Our first initiative is to integrate the mental health & disability services central point of coordination (CPC) into the community mental health center (MHC) system.

We believe that the MHC is best equipped to manage the mental health services of the community while the CPC role should be administrative. The establishment of the CPC system in 1996 had a negative impact on the original mission and intent of the community mental health center system. Many MHCs became outpatient clinics and turned their focus to therapy and med management and away from community support of individuals with chronic and persistent mental illness.

If we are successful, the MHCs will be the front door and lead agency for the delivery of mental health and disability services and an integrated, cost-effective, equitable safety net for our most vulnerable citizens.

The second initiative is to build institutional services within our community to fill the vacuum and barrier to the state run institutional system.

This is about resetting the balance in our partnership between the public and private service system. Just like in the current health care debate if we do not have a "public option" for individuals with high risk needs we will break our private provider network.

Closing state institutions often occurs under the magical assumption that individuals did not really need that level of support. An even worse assumption is that institutions are inherently bad. There are aspects of institutional care that can be more effectively delivered in the community but we must build that capacity because the only institutions currently available for high risk MHD needs are jails and hospitals.

If we are successful, we will bring and keep at home our residents with high behavioral health needs with institutional resources available to our private provider network. Effective institutions are the foundation of any successful community.

The third initiative is to pool dollars, administration, infrastructure, and enrollees.

Stakeholders criticize the county system for "mismanagement" when the problem is the challenge of keeping enough money in 99 different program silos. The State Payment Program is an excellent pilot project that demonstrates that county (local) management serves more individuals for less money while increasing provider reimbursement.

We continue this parlor game with funding formulas that inject perverse economic incentives into the system. Just one such economic incentive is the inflation factor received by county systems that operate large Medicaid agencies out of Fund 10. County Social Services reports nearly 8 million dollars as expenditures under the current funding formula. For every percent increase inflation factor under the current funding formula County Social Services receives $80,000 more than counties with pure purchase of service budgets.

If we are successful, this joint venture will provide one funding stream and one service plan across the five-county region. Administrative staff will organize around functional skill sets instead of geographic location. We will dramatically reduce clerical processes that do not add value to the system. We will eliminate the need to use legal settlement to allocate resources. We will produce outcome measures that will advance quality evidence based practice and the most effective and efficient delivery system.

Service Coordinators will reduce travel and increase access by coordinating a safety net of social services across the region with the mission of responding to any social service request within 2 hours. County Service coordinators will be the navigators for community services for all populations and all gaps in the service network that puts our most vulnerable citizens at risk.

Project History

The pilot project began in May of 2008 following the passage of Senate Bill 3297(see appendix) put forward by Senator Amanda Ragan and Representative Linda Upmeyer. This legislation gave counties an incentive to collaborate, explore a new partnership with DHS and try different methods of delivering mental health and disability services.

The County Social Services Project started with 12 counties from our MHC service areas and ended with just the 5 who had already been sharing an administrator. For Floyd, Butler, Cerro Gordo, Mitchell and Black Hawk Counties the process survived the devastating tornado of Parkersburg, the worst flooding in our region in the last 500 years, the worst economic recession since the 1930s, a leadership vacuum at DHS and the administrator's broken back.

The result was the creation of a separate legal entity called County Social Services established on January 1, 2009. DHS recognized this entity as a consortium for FY2009

funding. We were then able to leverage the existing funding formula while trying to develop an alternative funding arrangement that would preserve local control, be contract driven and restore the opportunity for local investment in the MHD system.

The two biggest organizational challenges were underwriting insurance for our new entity and convincing county employees to transfer employment to County Social Services. The insurance companies wanted everyone under one employer to create clear lines of liability. Conversely, in the midst of a severe recession and significant reorganization that always creates fears of job loss, employees were not willing to leave county employment with all the associated benefits.

Creating a separate legal entity also confronted us with new costs for services previously absorbed by the member counties-legal services, independent audit, payroll, human resources, legal notices, policies- the very costs we wanted to save with the collaboration. Our conclusion was a simple but subtle distinction. If we changed our 28E agreement to a joint sharing arrangement (essentially a partnership instead of a corporation), we could retain county employment and resources but still pool our dollars in one existing county Fund 10 account. This opened the opportunity to simplify the accounting for MHD services by rolling up the over complex chart of accounts and move MHD agencies out of Fund 10 into enterprise funds that will increase the ability to manage and show accountability to the public.

County Social Services is not the first consortium to share an administrator or to share a plan but it is the first fully integrated partnership that allows money, services, and enrollees to flow evenly across county lines. It is also the first opportunity for the state to test the many simplistic assumptions associated with sharing agreements. We will give you two assumptions that we know are not true. The first is that sharing automatically saves money and the second is that sharing is easy.

The key to successful sharing is unanimous consent from the elected officials that this is the best way to serve the needs of their county constituents. The next ingredient are county employees that can overcome their fear of loss to gain a more significant and valuable role in a larger endeavor. It takes very little to convince the community, enrollees, legislators and providers that this makes sense and provides a more sustainable and equitable MHD system.

Board Members

Each member county Board of Supervisors annually appoints their representative to the County Social Services Board:

Member	Appointed by:	Begin	End
Phillip Dougherty, Chair	Cerro Gordo County Board of Supervisor	1/1/2009	1/1/2010
Joel Voaklander, Vice-Chair	Mitchell County Board of Supervisor	1/1/2009	1/1/2010
Craig White	Black Hawk County Board of Supervisor	1/1/2009	1/1/2010
Warren Dunkel	Floyd County Board of Supervisor	1/1/2009	1/1/2010
Ken Oldenburger	Butler County Board of Supervisor	1/1/2009	1/1/2010
Bob Lincoln Ex-officio	Administrator		

Current County Mental Health & Disability System

MH Workgroup Assessment of Critical Needs

There is inadequate funding, the need for waiting lists, declining revenue projections, and the inequities among the counties relating to funding, levy rates and availability of services. There is a need to simplify the system with regard to funding and service delivery, the need for vertical and horizontal integration of the system, and the need to base the system on core principles and values that drive the development of services, rather than the funding streams and their corresponding services driving the system.

Some of the issues reviewed by the work group included:

1. Would restructuring the administration of the system reduce costs? Examples include combining central points of coordination or regionalization of services. Many states have restructured the administration of the system to reduce costs, instead of first determining what persons with disabilities need and then building the delivery system to fit these needs.
2. Are there savings in other areas that result from providing effective MHD services such as reduction in jail and prison time, avoidance of utilization of emergency rooms, etc. There is a need to look at overall outcomes, not just MHD system expenditures.
3. Are there other services that can be provided through the Medicaid program in order to obtain federal financial participation? There are tradeoffs in this approach, including loss of flexibility and increased requirements such as statewide uniformity, documentation, and auditing.
4. DHS is developing a comprehensive MHD system plan which includes defining principles, and completing a population-based needs assessment. Based on this

assessment, models can be built to determine cost. DHS will share the time frame for progress of the comprehensive plan with the work group.

5. Will substance abuse be included in the discussion?
6. Medicaid home and community-based services recipients sometimes also receive other sources of financial support such as social security's Supplemental Security Income (SSI) program. Could these other sources be tapped to reduce cost to the MHD system?
7. What is a base level of services? There is no definition of "core services." Many prior attempts at defining core services have failed because some believe "core services" would become the minimum set while others fear they would become the only services offered. Some like the idea of defining core principles and values rather that core services, and focusing on individual outcomes.
8. There is a philosophical disagreement among counties as to the appropriate amount of service to be made available. Attitudes differ at the local level.
9. How does the work group define the term "system" for its purpose? (Iowa General Assembly 2009 Committee Briefing, August 26, 2009)

Institutional Needs

There are 530 individuals currently receiving support services through the state resource centers of Woodward and Glenwood. In fiscal year, 2008 there were 10,600 applications for court ordered behavioral health intervention. These numbers will go down to the extent we are able to provide effective institutional resources in our community and should provide a peripheral reduction in hospitalizations and incarcerations.

Summary of Needs

The County Mental Health & Disability Services system is fragmented. It has different entry points for children, elderly, poor, and incarcerated. It is difficult to get the right level of funding to each program. When funding is unequal, the availability of services becomes inequitable.

The DHS Mental Health & Disability Services Division has identified three areas of improvement for the system that are consistent with the needs expressed by our consortium. The first is to expand access to mental health services for children. The second is a state wide mental health emergency response system. The third is an integrated system of care that delivers quality evidence-based care regardless of age, race, disability, poverty, or co-occurring conditions.

Project Platform for Change

County Social Services Plug and Play Collaboration

Our conclusion for the best legal platform for county collaboration is a joint venture partnership. We discovered that the creation of a separate or corporate public entity introduces too much organizational overhead and its own bureaucratic requirements.

Here are the elements we believe are essential for effective collaboration:

1. Each county Board of Supervisors unanimously approves an easy to understand partnership agreement.
2. A Supervisor annually appointed by their Board represents each member county.
3. The agreement commits all Fund 10 reserves, state MHD allocations and the full MHD property tax maintenance of effort.
4. All county employees paid through Fund 10 dollars are under the direction of the consortium's administrator.
5. All assets historically used by the MHD remain available.
6. Counties agree to support the role of Community Mental Health Centers and agree to one management plan.
7. Members agree to support the reorganization of staff to align with the functional needs of the consortium.
8. Members agree to pool all dollars to simplify money management.
9. Members agree to move all Medicaid reimbursed agencies out of Fund 10.
10. Members can unplug by giving notice prior to November 15th to terminate participation on June 30th with a per capita allocation of total accrued reserves.

County Social Services Proposed Delivery Model

> The key to savings in health care is not in the cost of treatment but in delivering care when and at what level necessary to address the need.

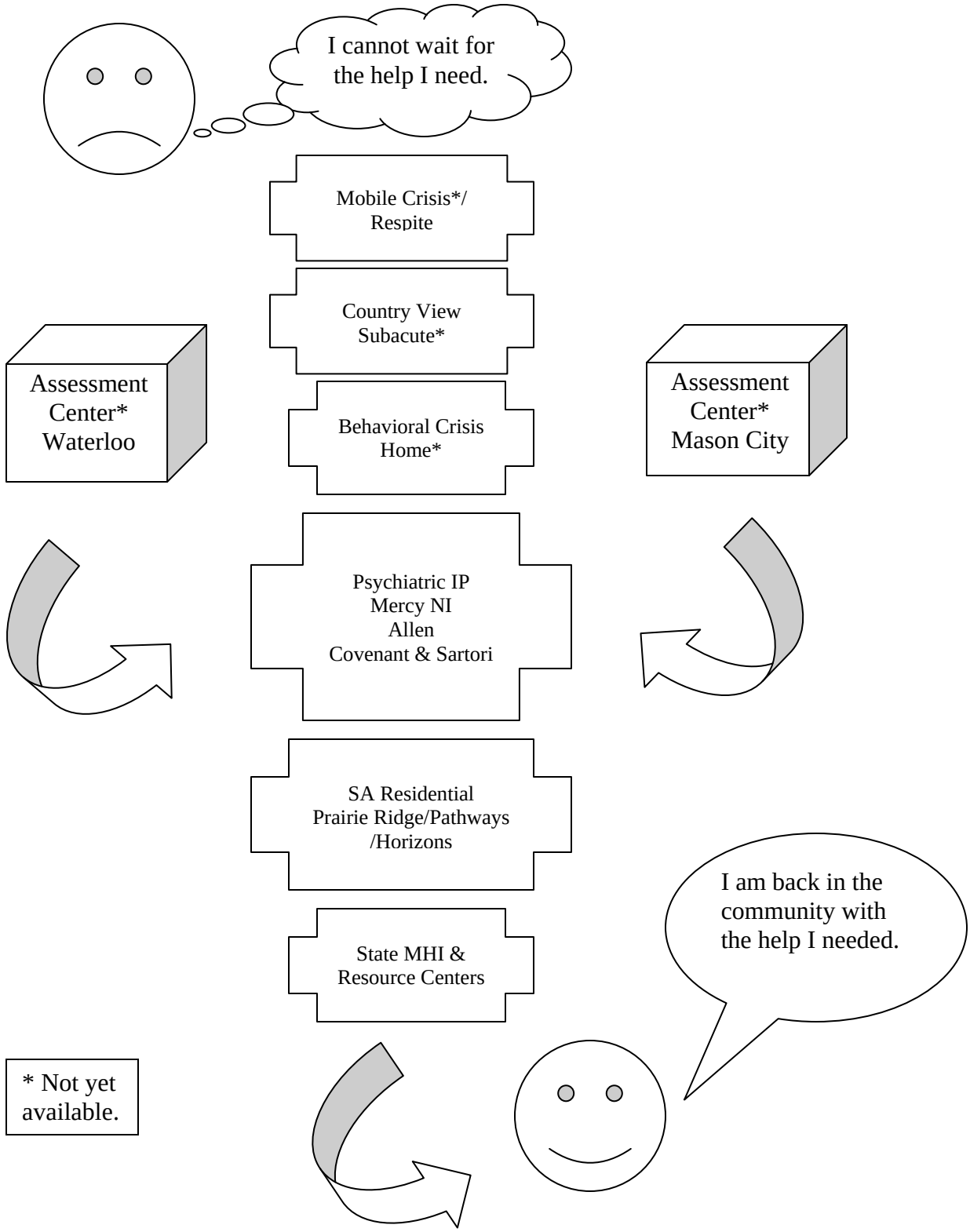
The two challenges to effective delivery are risk and rationing. In a public system, there is little incentive and therefore little tolerance for risk. Even if the service level was correct but it had a bad outcome the overwhelming reaction is to just add service or increase level of care.

Rationing is the allocation of resources when the population perceives that that there is not enough "pie" for everyone. Entitlement or "mandated services" push back against rationing by suggesting that the failure to provide early and proper support services will result in future costly institutional or mandated services.

We have concluded that the best way to manage risk is to build a system of institutional supports that will make crisis behavioral health services available to everyone and at the most appropriate level of intervention 24 hours a day.

To allocate resources we plan to add evidence based assessments that will compliment our direct knowledge and relationship with our clients to deliver the necessary level of care. Good evidence based measurements will encourage portion control and hopefully reduce the need to ration.

County Social Services Proposed MHD Infrastructure



Assessment Centers

The Assessment Center concept comes from consultation with Florida and a site visit to a center in Austin, Texas. How the model looks is not as important as when it is open.

In our Service Centers, we may have half of our scheduled appointments not show. Then we have more than that walk-in with urgent needs- "my utilities got shut-off"; "I am out of medication."; "my girlfriend kicked me out of my apartment"; 'I can't find a ride to my appointment;" "my life is a mess since my husband died." We propose that a place where individuals can walk-in when they are in need will save great deal of effort and lost time on no shows.

Waterloo and Mason City have enough population to staff Assessment or Access Centers as an extension of the designated MHCs, Black Hawk-Grundy Mental Health Center and Mental Health Center of North Iowa. At a minimum, they should be open 7:00 AM to 11:00 PM everyday of the year. The centers should seamlessly integrate with the CPC and TCM process to connect individuals with the support and level of care to meet the presenting need. The centers will also be the operating base for outreach, CSP and emergency mental health services. The centers should have access to psychiatric consult and should be the access point for all applications for civil commitments.

We hope to have both centers operating by July 1, 2011.

Country View ICF/PMI

Country View is developing a 16-bed ICF/PMI unit to address psychiatric stabilization needs that extend beyond the acute psychiatric inpatient at the private units and as a step down for individuals returning to the community from the state Mental Health Institute. With effective assessment and referral, they may also serve as a diversionary level of care for individuals at risk for inpatient care.

Country View has become a valuable public service to the region by serving the complex medical needs of individuals with behavioral health needs. We envision Country View becoming that essential institutional support to our community providers. We hope to have the ICF/PMI certified by July 1, 2011.

Behavioral Crisis Home

County Social Services hopes to develop a 4-bed crisis home modeled after Minnesota's unit in Kasson, MN. It will target individual's exhibiting unsafe behavior and apply positive behavioral interventions to assess, retrain and modify individual's community supports to help them successfully transition back home. We believe that this institutional resource is essential to give our provider network the capacity to serve greater challenges within their organization. We will need legislative and DHS support to make this proposal operational by January 1, 2012.

Positive Behavioral Support Network

With the leadership and resources of Road to Community, we are launching a network to provide collaborative training to our region's direct care workers. This initiative is shadowing much of the hard work already invested by Polk County Health Services. When some studies suggest that 85% of an individual's challenging behavior is related to poor staff training and intervention we must make this our first priority.

We have had onsite instructional training for Crisis Prevention Institute through Country View. We have had our first completed Mental Health First Aide class and will start our second when the new manuals are released. We are training and applying Dialectical Behavior Therapy to individuals with intellectual disabilities as well as substance abuse and mental illness.

County Service Centers

County Social Services is not only a horizontal collaboration between counties but is also vertically integrated with other community services within each county to facilitate one-stop shop for individuals in need. The management plan describes the co-location and collaboration of each County Service Center.

Management Plan

In April 2009, County Social Services adopted a unified Mental Health & Disability Services Management Plan. This does not suddenly make the same services available in all counties but it does remove a significant barrier. The complete Plan is available under a separate cover but here are a few features of the plan worth mentioning:

1. The plan covers developmental disability and brain injury.
2. There is a unified sliding fee schedule for the three MHCs that all counties in the service areas have agreed to use. It excludes resources and offers graduated co-payments up to 350 FPG.
3. The plan does cover the following services;
    a. specialized mental health services for individuals in jail and in community corrections,
    b. an array of substitute decision making services (payee, guardianship and conservatorship),
    c. voluntary mental health inpatient,
    d. hospital referees,
    e. supports school based mental health services,
    f. incorporates Toledo, and shelter care as a covered service to leverage more appropriate opportunities.
4. The plan introduces the use of standardized assessments (ICAP & LOCUS) for future resource allocations.

Organization & Management

County Social Services organizes around three primary functions; administration, service coordination and service provision. This project has made it possible for us to reassign workloads where we have the talent and capacity without having to "charge back" to the counties that received the benefit.

Administration

The administrative personnel allocate resources. They must make sure that all dollars are properly accounted and expended on behalf of eligible enrollees. Three administrative personnel meet the minimum qualifications for a CPC and therefore are able to make independent funding determinations. The Administrator has an MBA and has a Masters of Social Work License. We have designated a contract manager for the consortium and are developing a role for Communication Officer within one of our existing positions. We are behind with the use of the internet to communicate and leverage the existing County web sites for social marketing of behavioral health needs.

Service Coordination

We currently have three full-time service coordinators and use .5 ftes from our Medicaid Case Management program in Floyd County. Our proposed organizational chart has two unfilled service coordinator positions. One would be a lead position in Black Hawk County and the second would work between Mitchell and Butler County.

Service Coordinators do true social work and provide a safety net for the community. Service Coordinators serve that population that is not easily plugged into one program that will meet their needs. They are gap fillers.

The challenge for Service Coordinators under the new model is to add evidence based assessment tools and case manage population groups instead of cases. County Social Services hopes to implement the level of care program by January 1, 2011.

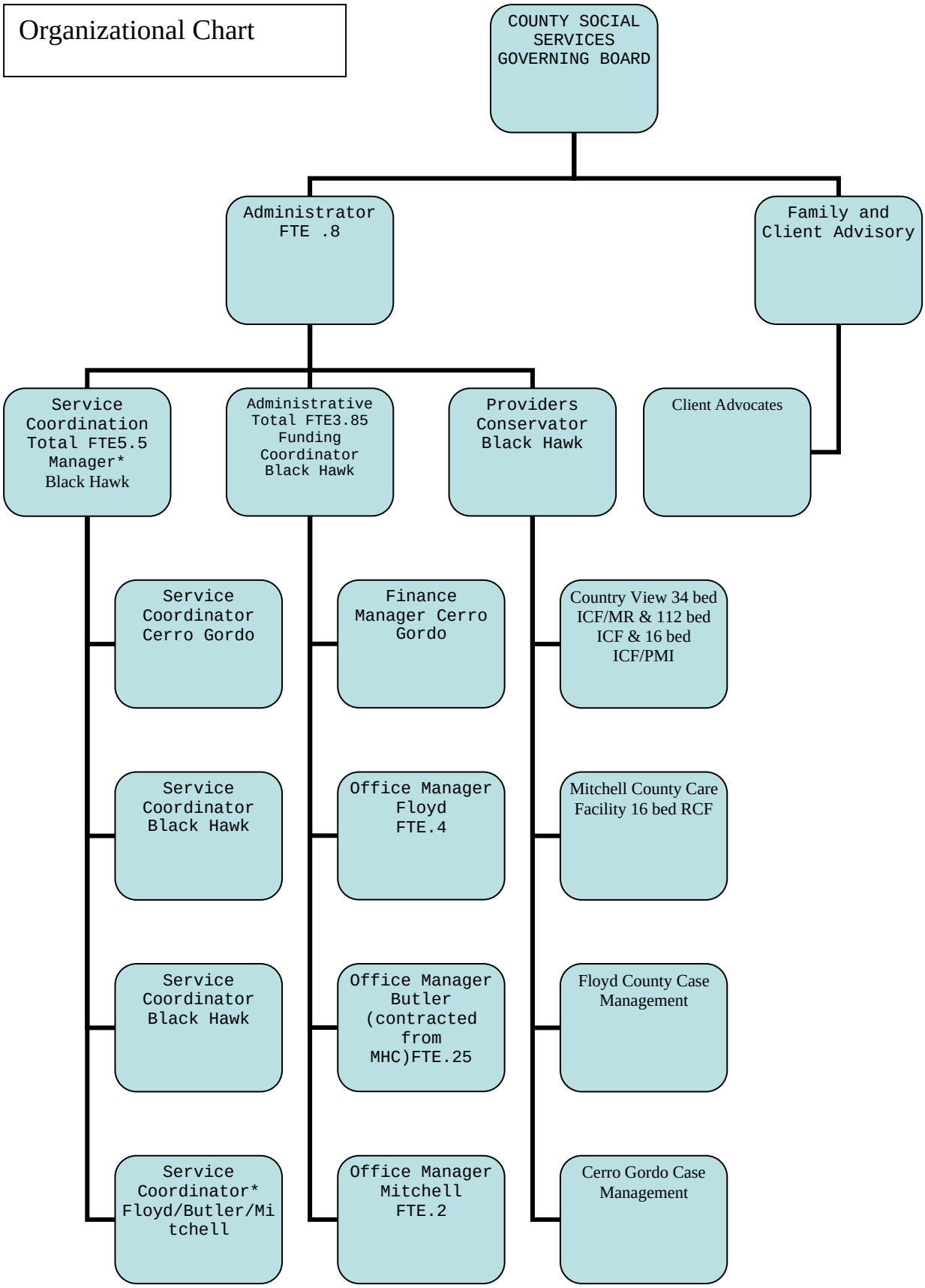
Service Provision

County Social Services supports the following public service providers under the MHD Fund 10:

- Black Hawk County Conservators
- Floyd County Case Management
- Cerro Gordo Case Management
- Black Hawk Country View
- Mitchell County Care Facility

We believe that these public service options are important as long as they complement and support our private service network. These services are the building blocks for the institutional supports of a successful community based system.

Organizational Chart



Financial

Regional FY2008 Totals	Total
Beg Fund Balance July 1, 2007	$1,992,895
Revenues:	
Property Tax	$9,689,996
State Allocation	$13,592,651
Medicaid Pass Through	$7,373,306
Total Revenue	$32,153,783
Actual Expenditures	$32,869,878
Revenues over/(under) expenditures	-$716,095
Ending Fund Balance June 30, 2008	$1,276,800
Ending Fund Balance % of Total Exp	**3.88%**

	Medicaid	County
Floyd	$947,282	$707,793
Butler	$974,190	$434,912
Cerro Gordo	$3,119,931	$2,734,469
Mitchell	$726,408	$519,583
Black Hawk	$9,192,202	$5,206,860
Total	$14,960,013	$9,603,617
	61%	39%

In FY2009 we would have "broke even" with our revenue and expenses. Then when you factor in the stimulus money that reduced our Medicaid Match by over $2,000,000 we now concerned that our FY2009 fund balance will be to high dramatically reducing our allocation in FY2011.

Going Forward

Medicaid

Medicaid is the best and worst reason to regionalize.

This is the first year that the state's allocation to County Social Services exceeded the dollars used for Medicaid match. If DHS took the Medicaid match from the county MHD budget and only property tax dollars remained there would be very little benefit to pool resources. Counties would take their money and go home. The county MHD system would become akin to county general assistance- just filling gaps while individuals wait for state and federal assistance programs.

On the other hand, if DHS chose to outsource capitated contracts for the delivery of MHD services, counties would need to regionalize. Counties would need to form regions with sufficient covered lives to be able to underwrite the risk of a capitated contract. This would be very similar to the Ohio and Wisconsin delivery models.

County Social Services believes that local control is valuable and that DHS must deliver a statewide MHD system that is accountable, effective and equitable.

County Social Services believes that a regional network under contract to DHS would deliver the outcomes and address many of the issues currently frustrating stakeholders.

Appendix

Proposals

First

County **F**inance **A**uthority

Inputs

- 11 COUNTIES
- 3 MENTAL HEALTH CENTERS
- 11 SUPERVISORS
- 100% MH/D PROPERTY TAX REVENUE
- 11 MH/D FUND BALANCES
- 5 ADMINISTRATORS
- 1 28E AGREEMENT
- 11 SERVICE CENTERS
- 1 DHS PER CAP/AT RISK CONTRACT

Outputs

- ✓ 1 MH/D MANAGEMENT PLAN
- ✓ 1 MH/D FUND
- ✓ 1 POLICY AUTHORITY
- ✓ 1 CONTRACT AUTHORITY
- ✓ 0 NO LEGAL SETTLEMENT WITHIN CFA
- ✓ 0 SERVICE INEQUITY ACROSS COUNTIES
- ✓ 0 STATE CASES
- ✓ COLLABORATION ALINED WITH MH/D DIVISIONS PLAN FOR SYSTEM CHANGE
- ✓ LOCAL INVESTMENT AND CONTROL
- ✓ SUFFICIENT POPULATION TO MANAGE RISK

Second

Regional Service Network

Consolidate state MH/D funding to 9 counties under a regional authority consisting of an appointed Supervisor from each member county. The Regional Service Network Board would have the authority to establish one plan and determine distribution of state funds to county service centers. The counties included in the Regional Service Network must be aligned with the Mental Health Center Service Areas.

Pros:

1. Increase Service equity
2. Eliminate legal settlement
3. Eliminate funding uncertainty
4. Build reserves to manage risk and reinvest in capacity building
5. Increase administrative efficiency
    a. Providers would only have to answer to one service center but have recourse to the Network Board to resolve disputes.
    b. County service centers would just manage their resident's needs reducing travel (see State Payment Plan)

Cons:

1. Counties would have to share money and control for the greater good of integrated services to our residents
2. DHS would purchase service coverage on a per capita basis from the Regional Service Network

MH/D Regional Service Pilot Project Senate Bill 3297

Senate Bill 3297 states:

a. The department of human services may establish a pilot project for a regional service network for county mental health, mental retardation, and developmental disabilities services paid for with the services funds under section 331.424A of the consortium of counties participating in the pilot project. The initial term of the pilot project is limited to the two-year period beginning July 1, 2008 and ending June 30, 2010.

b. Under the pilot project, the department may enter into an agreement with the counties participating in the pilot project to administer a risk-based contract with a third party for the mental health, mental retardation, and developmental disabilities services provided by the participating counties. The pilot project provisions may include but are not limited to all of the following:
   1) Pooling of the participating counties services fund moneys.
   2) Sharing of slots at state institutions for the participating counties.
   3) To the extent allowed under federal requirements, decategorizing the funding streams for mental health, mental retardation, and developmental disabilities available to the counties participating in the pilot project.
   4) If the department implements a new program, initiative, or service addressing the needs of the populations receiving services paid for by a county services fund, the department may adapt any associated requirements to optimize implementation within the pilot project counties.

c. For purposes of the allowed growth and MH/DD community services fund moneys distributed under this section, the minimum levy and services fund ending balances of the counties participating in the pilot project may be combined and an average utilized to qualify.

d. For the allowed growth and MH/DD community services fund moneys distributed for the fiscal year beginning July 1, 2009, provided the counties participating in the pilot project do not reduce levies below the required percentages, the combined percentage of those moneys of such counties shall not be less than the combined percentage of such moneys in the preceding fiscal year.

e. A county's participation in the pilot project and the provisions of the pilot project must be agreed upon by the department and the board of supervisors of each of the counties participating in the pilot project.

f. The department may specify a minimum population level and other prerequisite requirements for the consortium of counties participating in the pilot project.

g. The pilot project counties shall provide periodic performance and evaluation information to the department, governor, and general assembly."